LaPine Community HEALTH CENTER

Authorization to Release and Receive Protected Health Information

PO Box 3300 La Pine, OR 97739 Phone: 541-536-3435 Fax: 541-536-8047

Patient Name: _____ DOB:_____ LCHC PCP: _____

I authorize: (Person/Entity Releasing your PHI)

Name: _____

Address: _____

City: _____State: _____Zip: _____

Phone:_____Fax:_____

To Disclose to: (Person/Entity Receiving your PHI)

Name: _____

Address: _____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

Reason for Records Release:

☐ Continuity of Care ☐ Insurance ☐ Legal ☐ FMLA/Disability ☐ Return to Work ☐ Other _____

☐ Chart Notes from (Date)_____ to (Date) _____
☐ Immunization Records from (Date)_____to (Date)_____
☐ Lab Results from (Date) _____to (Date)_____
☐ Medication List from (Date) _____ to (Date)_____
☐ Radiology Report from (Date) _____to (Date)_____
☐ Pathology Report from (Date) _____to (Date)_____
☐ Genetic Testing from_____ to _____ Signature_____
☐ HIV/AIDS Records/Results from _____to_____ Signature_____
☐ STD Records/Results from _____ to _____Signature_____
☐ Mental Health Records from_____to_____Signature_____
☐ Behavioral Health Records from _____to_____Signature_____
☐ Drug/Alcohol Records from _____ to _____Signature_____

Records Release Format:

☐ **MYCHART – Free**
☐ Paper
☐ Electronic

Delivery Method:

☐ **MYCHART (MYCHART.OCHIN.ORG)** ☐ Pick up in person
☐ Mail to address above
☐ Fax to number above

This authorization may be revoked at any time, except when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 1 year from the date of signing. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. I understand that La Pine Community Health Center will provide this information within 30 days from the receipt of the completed request and that a $10.00 minimum fee for preparing and furnishing this information will be charged for all paper copies of records according to federal law.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____